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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CATHERINE JUNE WELLS** 1048 S. Winchester Blvd., #7 San Jose, CA 95128 **Registered Nurse License No. 566623,** Respondent.	Case No. 2008-156 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. **Catherine June Wells**. On or about May 2, 2000, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 566623 to Catherine June Wells ("Respondent"). The license will expire on December 31, 2007, unless renewed.

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JURISDICTION

3. Section 2750 of the Business and Professions Code ("Code") provides:

Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof. Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein.

STATUTORY PROVISIONS

4. Code section 2761 provides, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct . . .

. . . .

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

5. Code section 2762, subdivision (a), provides:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs

his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

6. Code section 2770.11 provides, in pertinent part:

(a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

7. Code section 4022 provides, in pertinent part:

"Dangerous drug" or "dangerous device" means...

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

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8. Code section 4060 provides:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse- midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

9. Health and Safety Code section 11173, subdivision (a), provides:

> (a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

10. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. "Darvocet" is a compound consisting of propoxyphene napsylate, a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (c)(2), and a is a dangerous drug within the meaning of Code section 4022.

12. "Dilaudid" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

13. "Fentanyl" is a Schedule II controlled substance pursuant to Health

and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Code section 4022.

14. "Morphine" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

15. "Propoxyphene (Propoxyphene Napsylate)" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (c)(2), and a dangerous drug within the meaning of Code section 4022.

16. "Versed" is a dangerous drug within the meaning of Code section 4022.

17. "Vicodin" is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

Background

18. Stanford Hospital and Clinics. Respondent was employed as a registered nurse in the Emergency Department of Stanford Hospital and Clinics (Stanford), located in Stanford, California, from on or about September 4, 2001, until on or about February 16, 2004.

19. An audit of Stanford's hospital and patient medical records from on or about January 19, 2004, through on or about February 12, 2004, disclosed that while working in the Emergency Department, Respondent obtained controlled substances and dangerous drugs from Stanford's "Pyxis" medication dispensing system[1] in contravention of physician orders and without physician orders to do so. On multiple occasions from on or about January 19, 2004, through on or about February 12, 2004, Respondent failed to properly account for the disposition of controlled substances and dangerous drugs in any

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1. "Pyxis" is a brand name for an automated medication dispensing and supply system manufactured by Cardinal Health Company. A PIN access code is used to access controlled substances from the system which automatically logs all transactions involving the removal of controlled substances, identifying the name of the person accessing the system, the patient's name for whom the substances have been ordered, and the date, time, and dosage being obtained.

hospital or patient record, or made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records pertaining to controlled substances and dangerous drugs.

20. Following the results of Stanford's audit, Respondent acknowledged that she had falsified hospital and patient records concerning the controlled substances and dangerous drugs identified in Stanford's record audit. Respondent also admitted that she obtained and diverted those substances for her personal use and self-administration.

21. The Board's Diversion Program. On or about March 4, 2004, Respondent was entered into the Board's substance abuse diversion program pursuant to Code section 2770.[2] Respondent's diversion record reflects three positive urine tests while participating in diversion. On or about July 6, 2004, and December 4, 2004, she tested positive for alcohol. And, on or about May 31, 2005, Respondent tested positive for Propoxyphene (Darvocet). Following her May 31, 2005 positive test result, Respondent was terminated from diversion on June 23, 2005, as a public safety threat.

FIRST CAUSE FOR DISCIPLINE

(False, Grossly Incorrect, Grossly Inconsistent, or Unintelligible Record Entries)

22. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (e), in that while employed at Stanford, Respondent made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances, as follows:

a. Patient "#1." On or about January 19, 2004, at approximately

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2. Code section 2770 provides:

> It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing a diversion program as a voluntary alternative to traditional disciplinary actions. (Bus. & Prof. Code, 2770.)

1235 hours, Respondent obtained one 2 mg dose of Dilaudid for administration to Patient #1. Patient"#1" had been discharged from Stanford at 1230 hours. Respondent inconsistently documented the wastage of the 2 mg dose of Dilaudid at 1402 hours, January 19, 2004, one and one-half hours after it had been obtained.

b. Patient "#2." On or about January 19, 2004, at approximately 1530 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #2. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #2 at 1308 hours, and 5 mgs of the Morphine to Patient #2 at 1500 hours, January 19, 2004.

c. Patient "#3." On or about January 19, 2004, at approximately 1833 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #3. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #3 at 1740 hours, and 5 mgs of the Morphine to Patient #3 at 1830 hours, January 19, 2004.

d. Patient "#4." On or about January 19, 2004, at approximately 1920 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #4. Respondent documented the wastage of 5 mg of the Morphine, but she inconsistently documented the administration of 5 mgs of the Morphine to Patient #4 at 1900 hours, January 19, 2004.

e. Patient "#5." On or about January 23, 2004, at approximately 1048 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #5. Respondent inconsistently documented the administration of 2 mgs of the Morphine to Patient #5 at 0840 hours, 2 mgs of the Morphine to Patient #5 at 0945 hours, and 2 mgs of the Morphine to Patient #5 at 1015 hours, January 23, 2004. Respondent also failed to account for the remaining 4 mgs of Morphine in any hospital, patient, or other record.

f. Patient "#6." On or about January 23, 2004, at approximately 1251 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #6. Respondent inconsistently documented the administration of 5 mgs of the Morphine to

Patient #6 at 1230 hours and 5 mgs of the Morphine to Patient #6 at 1340 hours, January 23, 2004.

g. Patient "#7." On or about January 23, 2004, at approximately 1606 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine for administration to Patient #7. Respondent documented the administration of 4 mgs of the Morphine to Patient #7 at 1610 hours, and the wastage of 6 mgs of the Morphine at 1606 hours.

h. Patient "#8." On or about January 23, 2004, at approximately 1648 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #8. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #8 at 1645 hours, January 23, 2004, and she failed to account for the remaining 5 mgs of Morphine in any hospital, patient, or other record.

i. Patient "#9." On or about January 23, 2004, at approximately 1836 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #9. Respondent inconsistently documented the administration of 10 mg of the Morphine to Patient #9 at 1735 hours, January 23, 2004, and she inconsistently documented the administration of 4 mgs of Morphine to Patient #9 at 1815 hours, January 23, 2004, without documenting that she had obtained the 4 mgs of Morphine for administration to the patient.

j. Patient "#10-A." On or about January 24, 2004, at approximately 1051 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #10-A. Respondent inconsistently documented the administration of 1 mg of the Dilaudid to Patient #10-A at 1045 hours, January 24, 2004, and she failed to account for the remaining 1 mgs of Dilaudid in any hospital, patient, or other record.

k. Patient "#10-B." On or about January 28, 2004, at approximately 0741 hours, Respondent obtained a 0.2 mg dose of Dilaudid for administration to Patient #10-B. Respondent inconsistently documented the administration of 0.2 mgs of the Dilaudid to Patient #10-B at 0730 hours, January 28, 2004.

l. Patient "#11." On or about January 25, 2004, at approximately

0747 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #11. Respondent inconsistently documented the administration of 5 mgs of the Morphine to the patient at 0710 hours, January 25, 2004, and she failed to account for the remaining 5 mgs of Morphine in any hospital, patient, or other record.

m. Patient "#12." On or about January 25, 2004, at approximately 1501 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #12. After canceling the Pyxis transaction, when queried by the Pyxis system as to the remaining quantity of Morphine on-hand, Respondent entered "expecting 1514, found 15." Respondent's entry created a Pyxis discrepancy report as to the actual quantity of Morphine currently on-hand.

n. Patient "#13." On or about January 25, 2004, at approximately 1451 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #13. Respondent inconsistently documented the administration of 5 mgs of the Morphine to the patient at 1420 hours, January 25, 2004, and she failed to account for the remaining 5 mgs of Morphine in any hospital, patient, or other record.

o. Patient "#14." On or about January 25, 2004, at approximately 1815 hours, Respondent obtained a 100 mcg dose of Fentanyl for administration to Patient #14. Respondent inconsistently documented that administration of 50 mcgs to the patient at 1815 hours and at 1840 hours, January 25, 2004. Respondent's documented administration of 50 mcgs of Fentanyl to Patient #14 at 1815 hours and at 1840 hours exceeded the administration dosage ordered by the patient's physician.

p. Patient "#15."

1. On or about January 28, 2004, at approximately 1342 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #15. Respondent documented the administration of 6 mg of the Morphine to Patient #15 at 1445 hours, and she failed to account for the remaining 4 mgs of the Morphine in any hospital or patient record.

2. On or about January 28, 2004, at approximately 1617 hours, without a physician's order to do so, Respondent obtained a 6-pak of Vicodin for administration

to Patient #15. Respondent inconsistently documented the administration of the 6-pak of Vicodin to Patient #15 at 1545 hours, January 28, 2004.

q. Patient "#16." On or about January 28, 2004, at approximately 1737 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #16. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #16 at 1435 hours, and 5 mgs of the Morphine to Patient #16 at 1625 hours, January 28, 2004.

r. Patient "#17." On or about January 29, 2004, at approximately 0838 hours, 0956 hours, and 1341 hours, Respondent obtained one 2 mg dose of Dilaudid each for administration to Patient #17. Respondent charted the administration of 1 mg of Dilaudid to the patient at 0905 hours and at 1020 hours, and she made an unintelligible entry in Patient #17's medical record documenting that a 1 mg dose of the Dilaudid had been administered to the patient at approximately 0800 hours. Respondent failed to account for the remaining 3 mgs of the Dilaudid in any hospital or patient record.

s. Patient "#18."

1. On or about January 29, 2004, at approximately 1605 hours, Respondent obtained one 10 mg dose of Morphine for administration to Patient #18. Respondent documented the administration of 2 mgs of the Morphine to Patient #18 at 1605 hours, 1620 hours, and at 1825 hours, and she inconsistently documented that 10 mgs of the Morphine had been wasted at 1938 hours, January 29, 2004.

2. On or about January 29, 2004, at approximately 1931 hours, Respondent obtained one 10 mg dose of Morphine for administration to Patient #18. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

t. Patient "#19."

1. On or about January 29, 2004, at approximately 1713 hours and 1926 hours, Respondent obtained a 10 mg dose of Morphine each time for administration to Patient #19. Respondent charted the administration of 4mgs of the Morphine at 1800 hours, 1840 hours, and the wastage of 10 mgs of the Morphine at 1940 hours. Respondent failed to

account for the remaining 2 mgs of the Morphine in any hospital or patient record.

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2. On or about January 29, 2004, at approximately 1902 hours, Respondent documented the administration of 2 mg of Versed to Patient #19, bust she failed to document that 2 mgs of Versed had been obtained for administration to the patient.

u. Patient "#20."

1. On or about February 3, 2004, at approximately 1242 hours, without a physician's order to do so, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #20. Respondent failed to account for the 6-pak dose of Vicodin in any hospital or patient record.

2. On or about February 4, 2004, at approximately 1020 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #20. Respondent charted the administration of 5 mgs of the Morphine to Patient #20 at 1220 hours, but she failed to account for the remaining 5 mgs of the Morphine in any hospital or patient record.

v. Patient "#21." On or about February 3, 2004, at approximately 1312 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine for administration to Patient #21. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

w. Patient "#22." On or about February 3, 2004, at approximately 1218 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #22. Respondent inconsistently documented the administration of 2 mgs of the Morphine to Patient #22 at 1217,February 3, 2004, and she failed to account for the remaining 8 mgs of the Morphine in any hospital or patient record.

x. Patient "#23." On or about February 5, 2004, at approximately 0841 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #23. Respondent inconsistently documented that the 10 mgs of the Morphine had been wasted at 1847 hours, February 5, 2004, ten hours after it had been obtained. Patient #23 was not one of Respondent's assigned patients.

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y. Patient "#24." On or about February 5, 2004, at approximately 1146 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #24. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

z. Patient "25." On or about February 5, 2004, at approximately 1527 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #25. Respondent charted the administration of 4 mgs of the Morphine at 1530 hours, but she failed to account for the remaining 6 mgs of the Morphine in any hospital or patient record.

aa. Patient "#26." On or about February 5, 2004, at approximately 1028 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #26. Respondent failed to account for 2 mgs of the Morphine in any hospital or patient record.

ab. Patient "#27." On or about February 5, 2004, at approximately 1146 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #27. Respondent inconsistently documented the administration of 4 mgs of the Morphine to Patient #27 at 1328 hours, 4 mgs of the Morphine to Patient #27 at 1135 hours, and 2 mgs of the Morphine to Patient #27 at 1140 hours, February 5, 2004.

ac. Patient "#28." On or about February 7, 2004, at approximately 2003 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #28. Respondent inconsistently documented the wastage of 6 mgs of the Morphine at 0022 hours, February 7, 2004.

ad. Patient "#29." On or about February 7, 2004, at approximately 2034 hours, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #29. Respondent inconsistently documented the administration of a 6-pak dose of Vicodin to Patient #29 at 2030 hours, February 7, 2004.

ae. Patient "#30." On or about February 8, 2004, at approximately 0112 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #30. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient

#30 at 1925 hours, and 5 mgs of the Morphine to Patient #30 at 2230 hours, February 7, 2004.

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af. Patient "#31." On or about February 8, 2004, at approximately 0312 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #31. Respondent documented the administration of 5 mgs of the Morphine to Patient #31 at 0320 hours, and 5 mgs of the Morphine to Patient #31 at 0345. Respondent's documented administration of 5 mgs of Morphine to Patient #31 at 0345 hours exceeded the administration dosage ordered by the patient's physician.

ag. Patient "#32." On or about February 8, 2004, at approximately 1941 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #32. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

ah. Patient "#33."

1. On or about February 8, 2004, Respondent obtained a 10 mg dose of Morphine for administration to Patient #33 at approximately 2041 hours. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #33 at 2020 hours, February 8, 2004, and she failed to account for the remaining 5 mgs of the Morphine in any hospital or patient record.

2. On or about February 9, 2004, at approximately 0316 hours, without a physician's order to do so, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #33. Respondent failed to account for the 6-pak dose of Vicodin in any hospital or patient record.

ai. Patient "#34." On or about February 8, 2004, at approximately 1941 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine for administration to Patient #34. Respondent charted the administration of 2 mgs of the Morphine to Patient #34 at 0203 hours, but she failed to account for the remaining 8 mgs of the Morphine in any hospital or patient record.

aj. Patient "#35." On or about February 9, 2004, at approximately

0327 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #35. Respondent inconsistently charted the administration of 4 mgs of the Morphine to Patient #35

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at 0005 hours, 2mgs of the Morphine at 0050 hours, and 4 mgs of the Morphine at 0240 hours, February 9, 2004.

ak. Patient "#36." On or about February 9, 2004, at approximately 0024 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine for administration to Patient #36. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

al. Patient "#37." On or about February 9, 2004, at approximately 0328 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #37. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #37 at 0250 hours, and 5 mgs of the Morphine to Patient #37 at 0323 hours, February 9, 2004.

am. Patient "#38." On or about February 10, 2004, at approximately 0056 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #38. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #38 at 2210 hours, and 5 mgs of the Morphine to Patient #38 at 0006 hours, February 11, 2004.

an. Patient "#39." On or about February 9, 2004, at approximately 2335 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #39. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #39 at 0005 hours, and 5 mgs of the Morphine to Patient #39 at 0135 hours, February 9, 2004. Respondent's documented administration of 5 mgs of Morphine to Patient #39 at 0005 hours and 0135 hours exceeded the total administration dosage ordered by the patient's physician.

ao. Patient "#40."

1. On or about February 10, 2004, at approximately 0452 hours, Respondent obtained a 20 mg dose of Morphine for administration to Patient #40.

Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #40 at 0145 hours, 5 mgs of the Morphine to Patient #40 at 0210 hours, 5 mgs of the

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Morphine to Patient #40 at 0245 hours, and 5 mgs of the Morphine to Patient #40 at 0445 hours, February 10, 2004.

2. At approximately 0638 hours, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #40. Respondent inconsistently documented the administration of the 6-pak dose of Vicodin to Patient #28 at 0635 hours, February 10, 2004.

ap. Patient "#41."

1. On or about February 10, 2004, at approximately 0238 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #41. Respondent inconsistently documented the administration of 2 mg of the Dilaudid to Patient #41 at 0200 hours. Respondent also documented the administration of 1 mg of the Dilaudid to Patient #41 at 0240 hours, and 1 mg of the Dilaudid Patient #41 at 0240 hours. Respondent's documented administration of 1 mgs of the Dilaudid to Patient #41 at 0240 hours exceeded the total administration dosage ordered by the patient's physician.

2. On or about February 10, 2004, at approximately 0438 hours, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #41. Respondent inconsistently documented the administration of the 6-pak dose of Vicodin to Patient #41 at 0300 hours, February 10, 2004.

aq. Patient "#42." On or about February 10, 2004, at approximately 2357 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #42. Respondent charted the administration 5 mgs of the Morphine to Patient #42 at 0400 hours. Respondent failed to account for the remaining 5 mgs of the Morphine in any hospital or patient record. Respondent's documented administration of 5 mgs of Morphine to Patient #42 at 0400 hours exceeded the total administration dosage ordered by the patient's physician.

ar. Patient "#43." On or about February 11, 2004, at approximately 0005 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #43.

Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

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as. Patient "#44."

1. On or about February 11, 2004, at approximately 0105 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #44. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #44 at 0100 hours, February 11, 2004.

2. On or about February 11, 2004, at approximately 0539 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #44. Respondent inconsistently documented the administration of 5 mg of the Morphine to Patient #44 at 0530 hours, February 11, 2004, and she failed to account for the remaining 5 mgs of the Morphine in any hospital or patient record.

at. Patient "#45." On or about February 11, 2004, at approximately 0137 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #45. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #45 at 0130 hours, February 11, 2004.

au. Patient "#46." On or about February 11, 2004, at approximately 0522 hours, Respondent obtained two Vicodin tablets for administration to Patient #46. Respondent inconsistently documented the administration of one of the Vicodin tablets to Patient #46 at 0520 hours, February 11, 2004, and she failed to account for the remaining tablet of Vicodin in any hospital or patient record.

av. Patient "#47."

1. On or about February 12, 2004, at approximately 0007 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #47. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #47 at 1750 hours, and 5 mgs of the Morphine to Patient #47 at 1920 hours, February 11, 2004.

2. On or about February 12, 2004, at approximately 0505 hours,

Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #47. Respondent inconsistently documented the administration 2 mgs of the Dilaudid to Patient #47 at 0135 hours, February 12, 2004.

3. On or about February 12, 2004, at approximately 0505 hours, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #47. Respondent inconsistently documented the administration of the 6-pak dose of Vicodin to Patient #47 at 0255 hours, February 12, 2004.

aw. Patient "#48." On or about February 12, 2004, at approximately 0006 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #48. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

ax. Patient "#49." On or about February 12, 2004, at approximately 0320 hours, without a physician's order to do so, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #49. Respondent charted the administration of the 6-pak dose of Vicodin to Patient #49 at 0320 hours.

ay. Patient "#50." On or about February 12, 2004, at approximately 0156 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #50. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

az. Patient "#51." On or about February 12, 2004, at approximately 0321 hours, without a physician's order to do so, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #51. Respondent's documented the administration of the 6-pak dose of Vicodin to Patient #51 at 0325 hours.

ba. Patient "#52."

1. On or about February 12, 2004, at approximately 0139 hours Respondent obtained a 10 mg dose of Morphine for administration to Patient #52. Respondent inconsistently documented the administration of 5 mgs of the Morphine to Patient #52 at 0048 hours, 4 mgs of the Morphine to Patient #52 at 0255 hours, 4 mgs of the Morphine to Patient #52 at 0310 hours, and 4 mgs of the Morphine to Patient #52 at 0420 hours, February 12, 2004. Respondent's documented administrations of 4 mgs of Morphine to

Patient #52 at 0255 hours, 4 mgs of Morphine to Patient #52 at 0310 hours, and 4 mgs of Morphine to Patient #52 at 0420 hours were inconsistent in that they exceeded the total dosage of Morphine obtained by Respondent at 0139 hours.

2. On or about February 12, 2004, at approximately 0634 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #52. Respondent failed to account for the 10 mg of the Morphine in any hospital or patient record.

3. On or about February 12, 2004, at approximately 0138 hours, Respondent obtained a 6-pak dose of Vicodin for administration to Patient #52. Respondent inconsistently documented the administration of the 6-pak dose of Vicodin to Patient #52 at 0135 hours, February 12, 2004.

bb. Patient "#53." On or about February 12, 2004, at approximately 0526 hours Respondent obtained a 10 mg dose of Morphine for administration to Patient #53. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

bc. Patient "#54." On or about February 12, 2004, at approximately 0442 hours and 0527 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine each time for administration to Patient #54. Respondent charted the administration of 2 mgs of the Morphine to Patient #54 at 0442 hours 0450 hours, and at 0505 hours, and the wastage of 10 mgs of the Morphine at 0701 hours. Respondent failed to account for the remaining 2 mgs of the Morphine in any hospital or patient record. Respondent's documented administration of 2 mgs of the Morphine to Patient #54 at 0450 hours, and at 0505 hours exceeded the total administration dosage ordered by the patient's physician, and Respondent's documented administration of 2 mgs of Morphine to Patient #54 at 0442 and 0527 hours was an inconsistent record entry in that Patient #54 was not been admitted to Stanford until 0545 hours, February 12, 2004.

bd. Patient "#55." On or about January 19, 2004, at approximately 0950 hours, without a physician's order to do so, Respondent obtained a 10 mg dose of Morphine for administration to Patient #55. Respondent documented the wastage of the 10 mgs dose of Morphine at 0945.

be. Patient "#56." On or about January 19, 2004, at approximately 1837 hours, Respondent obtained a 10 mg dose of Morphine for administration to Patient #56. Respondent failed to account for the 10 mgs of the Morphine in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Wrongfully Obtaining, Possessing,

and Self-administering Controlled Substances and/or Dangerous Drugs)

23. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (a), in that from on or about January 19, 2004, through February 12, 2004, while employed at Stanford, Respondent did the following:

a. Wrongfully Obtaining Controlled Substances and/or Dangerous Drugs. As set forth under paragraph 22 above, Respondent obtained Dilaudid, Fentanyl, Morphine, Vicodin by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a).

b. Wrongfully Possessing Controlled Substances and/or Dangerous Drugs.

1. As set forth under paragraph 22 above, Respondent possessed Dilaudid, Fentanyl, Morphine, Vicodin without a valid prescription therefor, in violation of Code section 4060.

2. On or about May 31, 2005, Respondent possessed Propoxyphene (Darvocet), without a valid prescription therefor, in violation of Code section 4060.

c. Wrongfully Self-administering Controlled Substances and/or Dangerous Drugs.

1. By her own admission, while employed in the Emergency Department at Stanford, Respondent self-administered Dilaudid, Fentanyl, Morphine, and Vicodin, without the direction of a licensed physician, surgeon, dentist, or podiatrist.

2. On or about May 31, 2005, while participating in the Board's Diversion Program, Respondent self-administered Propoxyphene (Darvocet), without the direction of a licensed physician, surgeon, dentist, or podiatrist.

THIRD CAUSE FOR DISCIPLINE

(Conviction of Crime)

24. Respondent's license is subject to discipline under Code section 2761, subdivision (f), in that on or about July 12, 2006, in the case entitled, *"People v. Catherine June Wells"* (Super. Ct. Santa Clara County, 2006, No. BB620841), Respondent was convicted by the court upon a plea of no contest of violating Vehicle Code section 23152, subdivision (b), a misdemeanor, and a crime substantially related to the qualifications, functions or duties of a registered nurse within the meaning of California Code of Regulations, title, section 1444. The circumstances of the convictions are that on or about April 21, 2006, Respondent drove a vehicle while having 0.08 percent and more, by weight, of alcohol in her blood.

FOURTH CAUSE FOR DISCIPLINE

(Conviction of a Criminal Offense Involving the Consumption of an Alcoholic Beverage)

25. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (c), in that, as set forth under paragraph 24, above, Respondent was convicted of a criminal offense involving the consumption of an alcoholic beverage.

FIFTH CAUSE FOR DISCIPLINE

(Dangerous or Injurious Use of Controlled Substances and/or Dangerous Drugs and an Alcoholic Beverage)

26. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, in that Respondent did the following:

a. On multiple occasions from on or about January 19, 2004, through February 12, 2004, by her own admission while employed at Stanford, Respondent used Dilaudid, Fentanyl, Morphine, and Vicodin, to such an extent or in such a manner as to be dangerous or injurious to himself, any other person, or the public, or to such an extent that such usage impaired Respondent's ability to conduct with safety to the public the practice authorized by his license.

b. As set forth under Paragraph 23(c)(2), on or about May 31, 2005, while participating in the Board's Diversion Program, Respondent use of Propoxyphene (Darvocet) to such an extent or in such a manner as to be dangerous or injurious to Respondent, any other person, or the public, or to such an extent that such usage impaired Respondent's ability to conduct with safety to the public the practice authorized by his license.

c. As set forth under paragraph 24, above, Respondent used an alcoholic beverage to such an extent or in such a manner as to be dangerous or injurious to himself, any other person, or the public.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 566623, issued to Catherine June Wells;

2. Ordering Catherine June Wells to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/9/07

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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